L O O E U R B A N D I S T R I C T

A N N U A L R E P O R T

O F T H E

M E D I C A L O F F I C E R O F H E A L T H

F O R T H E Y E A R

1952

P.J. Fox

M.B.,B.CH., B.A.O.,D.P.H.

LOOE URBAN DISTRICT.

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH FOR THE YEAR, 1952

To the Chairman and Members of the Looe Urban District Council.

Mr. Chairman, Ladies and Gentlemen,

In presenting my Annual Report for the year 1952 my first and obvious duty is to comment on the general health of the population which resides in the six County Districts which make up Health Area No. 7. I should like to make it clear at the outset that much of what I have to say in this respect is based not on incontrovertible facts and figures but on opinions and impressions I have formed while living and working amongst the people of this part of Cornwall. The more obvious matters of being born, of dying, of contracting disease can be measured with some degree of precision, and their impact upon the community can be compared with that of previous years or that of other communities in the same year. For matters of life and death our yardstick is reasonably effective but for assessing the relationship of health, or more often the lack of it, to normal day-to-day living we are driven back to some extent on speculation and guesswork. We know from the heavy demands placed upon the National Health Service that there is a great deal of chronic ill-health, much of it vague in character; and based upon psychological disorders. These latter exist as one of the undesirable by-products of our modern civilisation, with its diverse anxieties, and its increased tempo of living, and there does not at present seem to be any obvious or easily available remedy. It would not however be reasonable to dismiss the problem on such a pessimistic note, without making some effort to solve it, but before doing so we must know more of its nature and extent. To collect this information is a task of very great magnitude, since the manifestations of chronic ill-health have an almost infinite variety, and its root may lie tangled and deep in human experience. Nevertheless if any worthwhile advance is to be made in our endeavours to tackle this problem, we must somehow or other gain the knowledge which will enable us to plan the eradication of this type of disease in the same way in which we have disposed of those more obvious diseases which used to cause so much human suffering and loss of life.

From the figures which are available to me, and my personal impressions, it appears to me that the health of the community in South-East Cornwall was up to average during 1952 The population of the area showed a decrease of 497 as compared with 1951, the total estimated mid-year population being 53,520. The County Districts showing decreases were St. Germans Rural District, Torpoint Urban District, Liskeard Borough and Looe Urban District, whilst Liskeard Rural District and Saltash Borough showed small increases in population. The total number of births 742 shows a small increase over the 1951 figure and the birth rate shows a corresponding small increase. The total number of deaths 709 shows a decrease as compared with the 1951 figure of 726, and the death rate is below the 1951 rate. The rates for maternal mortality, and infant mortality show small increases as compared with those of 1951, but the numbers are not large enough to allow of any useful deductions being drawn. As far as the principal well-defined causes of death are concerned heart disease again figures as the most prominent cause of death, with cancer as the next most common cause, followed by cerebral vascular lesions (stroke).
In 1952 heart disease caused 39% of the total deaths a small reduction over the 1951 figure of 41%. On the other hand cancer as a cause of death has shown an absolute increase from 92 in 1951 to 102 in 1952, representing a relative increase from 12.6% to 14.4% of the total deaths. Figures for the Area and its constituent County Districts appear in more detail as Appendix 1 of this report.

This year I have compiled an additional appendix - Appendix 2 which provides a more detailed analysis of the two most numerous causes of death -- heart disease and cancer. In recent years the attention of the medical profession and the general public has been increasingly drawn to the coronary disease as a frequent cause of sudden death, which strikes down men and women who have appeared to be healthy, and who in many instances were not aware that they suffered from heart disease. In coronary disease the blood vessels which supply the muscle of the heart itself become diseased as a result of which the blood supply to the heart muscle is interfered with and fails. This disease of the coronary arteries is part of the general pattern of disease which affects the arteries of the body from middle age onward, and comes under the popular description of "hardening of the arteries". Certain features about coronary disease are difficult to understand or explain. It is for instance more common in those whose occupation involves mental strain and worry, and less common in those whose occupation involves physical exertion. It would therefore appear to be, like peptic ulcer, a disease brought about by the worry, stress and the increased tempo of modern civilized conditions. Much research work has been done and is being done to find out why mans arteries, and particularly his coronary arteries, should degenerate, become diseased and fail long before his other tissues have worn out. Whilst certain facts are known, and certain deductions are possible there is at present no real answer to the problem of coronary disease which continues to take its tragic toll in sudden death. It can be seen from the figures in Appendix 2 that during 1952 coronary disease caused 30% of all deaths from heart disease in this Area.

In a world where many of the diseases which formerly caused early or untimely death have been greatly reduced in numbers, cancer stands out in sharper relief as a very potent cause of death. In this Area it was during 1952 second in the list of principal causes of death, accounting for 14% of all deaths during the year. Of the clearly defined cancers that affecting the stomach was numerically greatest, but the less well-defined cancers which appear in Appendix 2 under the head "various other cancers" were responsible for the greatest number of deaths. In recent years there has been a definite increase in the mortality from cancer. Some of the increase is real, that is, due to an actual increase in the incidence of cancer, whilst some of it is apparent, that is, due to better diagnosis and recognition of disease which previously went unrecognised. Coincidental with this increase in cancer mortality the whole subject has been receiving greater attention from medical and scientific workers and a great deal of research has been and is being carried out into possible causes of cancer. If and when these causes are uncovered it is reasonable to hope and believe that effective remedies will be found, but up to the present the causes of cancer remain largely hidden. Not unnaturally the subject of cancer is one which interests the general public, and one which tends to receive an increasing amount of publicity in the press and in periodicals. As to whether this publicity is a good thing it is difficult to say, and opinions are divided on the matter. It would perhaps be fair to say that the publication of bare statistics without comment or explanation would not be wise, tending to create an unreasoning fear of the disease. If the general public is to be informed about cancer, such information must be conveyed in the most careful and tactful manner, and even then, it may not be possible to avoid creating in some individuals a "cancerphobia" with all its attendant unhappiness. What we really want to get across to people is the fact that much cancer is curable if it is taken in hand in its early stages.

Whether this can be done without causing undue alarm, and worry is something on which it is most difficult to form a reliable judgement. Probably nothing short of experimental cancer education campaigns would yield reliable information on the subject. As far as this Area is concerned there is perhaps some small comfort in the fact that over the past five years there has been no real increase in cancer mortality, and in fact the figure for 1952 is slightly below the average annual figures for the period 1948-1952.

In 1952 the incidence of notifiable infectious disease was low, the total of 234 cases being the lowest recorded in the five years 1948-1952. The diseases which normally cause large fluctuations in yearly totals - measles and whooping cough - were not very active in 1952. Of the more serious infectious diseases there was one case of diptheria in an unimmunised adult, one fatal case of encephalitis in a 12 year old boy, and two non-fatal cases of meningococcal meningitis in young children. In a year in which the incidence of poliomyelitis in England and Wales was above the average we were fortunate in having no cases of this disease in this Area. In connection with Poliomyelitis it is encouraging to be able to report that as a result of intensive research work, principally in America, the prospect of preparing a vaccine to prevent the onset of poliomyelitis is brighter. It is as yet much too early to say whether the solution to the control of poliomyelitis is in sight but we have good hopes that it is not too far away. I am also glad to be able to report that a vaccine to protect against whooping cough was made available towards the end of the year. Although it may not have the spectacular success which attended the use of ante-diptheritic vaccine we hope it may reduce the incidence and severity of whooping cough amongst children. Whilst on the subject of protective inoculation, may I add my voice to those who have warned of the danger of becoming careless or indifferent about having young children protected against diptheria. Many young parents have hazy memories of the disease, and because it seldom rears its ugly head in their midst, they may become confirmed in the belief that diptheria has disappeared from the world and there is no need to have their children protected against it. It cannot be repeated too often or with too much emphasis, that unless the immunity of young children against diptheria is maintained by timely immunisation, this disease will again come amongst us to reap its tragic harvest of young lives.

Families, who by their social behaviour, leading as it does to the placing of uncommonly heavy demands on social services, are not inappropriately known as "problem families". The great majority of these families are characterized by mental subnormality, coupled with a fine disregard for the rules of life and conduct which govern our highly organised society. Of the parents the father is capable of low-grade, unskilled work only, and may often be irregularly employed or unemployed. The mother is usually a hopeless manager and housekeeper who soon gives up the unequal struggle against the filth and squalor which see and her family create all about them. A considerable part of the family income is spent on tobacco and alcohol, and the remainder is frittered away by poor domestic economy. When first encountered the state of the family may be ascribed to poor housing conditions, but to transfer to a better house with reasonable amenities makes little difference to the mode of life of a true problem family. On the contrary the increased rent of such a house lays upon them an increased burden which most of them cannot or will not carry.

Add to this the damage and delapidation they cause in the house, and the sense of resentment their presence engenders in their more normal neighbours, and it is not difficult to appreciate the reluctance of housing authorities to accept these families as tenants. It appears that if these families, and particularly the children, are to be helped, and rehabilitated, something in the nature of a team of social workers is needed to go into the home and there, working with, and virtually becoming part of the family, to endeavour to raise the standard of life and conduct of the family to something approaching normality. Such teams or family service units have been formed and used in large urban communities and they appear to have achieved some success. Obviously they could not operate so effectively in a thinly populated area mainly rural in character, and it is therefore fortunate that in such areas problem families are not so numerous, nor have their members the same opportunities for indulging in serious crime or juvenile delinquency. As a matter of interest there are in this Area about 30 families who provide in greater or less degree some problem to our social workers which calls for frequent visiting, and much effort to improve and educate them to a better standard of life for themselves, and a better standard of behaviour towards the rest of the community. Progress can be and often is painfully slow, but we always hope for better things from the growing generation of these families, and here and there our hopes are rewarded. One thing beyond doubt is the necessity to continue helping even the worst and most hopeless of these families. To abandon them to their own devices is to add further to the members who batter upon and exploit the resources of modern society.

The welfare of old persons continued to cause some anxiety during 1952. Several cases of old persons living alone in squalid and insanitary conditions came to notice during the year. In some cases the old persons were persuaded to accept accommodation in a hospital or institution where they could be cared for, and in other cases assistance provided by relatives, home helps, and the district nurse enabled them to remain at home, where living under reasonable if not ideal conditions they were much happier. It has been said that in modern times old people are being left a great deal to fend for themselves as far as care and assistance from relatives is concerned. This is unfortunately true in many cases and is an inevitable result of the state of mind which the Welfare State creates in many people, in consequence of which they believe that the state is able and willing to take over their personal cares and responsibilities. On the other hand we must in justice take cognisance of the genuine difficulties which prevent many will-intentioned people from caring for their old relatives. One of these is the physical separation, sometimes by long distances, between old people and their kin. This is one of the results of easy travel and the tendency of younger people to move away from mainly rural areas to larger centres of population. Another difficulty encountered in these cases is the friction and dissension which results from the differing outlook of old people, and their younger relatives, and here it must be admitted that some old persons can be extremely cantankerous, and make unreasonable demands on those who endeavour to care for them. I do not wish to over-emphasise or dwell unduly on these shortcomings and the difficulties they create, but I think it only right that they should be known. If all that one might wish to do for old people in the closing years of their lives is not always done, the blame cannot always be placed on those who may have tried to help. A great many old people are happy living alone, and manage very well with a little outside assistance. In some cases however the failing capacity, part mental, part physical, of old people to care for themselves manifests itself in the falling away of their living standards.

Their houses become verminous and insanitary, and they themselves become filthy in person, and habits. They moreover suffer from malnutrition because of their inability to prepare proper meals for themselves, whilst their dependence on paraffin oil for heating , and lighting creates a considerable danger of fire for themselves and their neighbours. Such are the pathetic cases of old persons which come to my notice, and in which I am forced to intervene to persuade them to accept outside help or to move into a hospital or institution where they will be cared for. Where persuasion fails I am empowered to bring the case before a Court of Summary Jurisdiction where if the Bench thinks fit an order for the removal of the old person may be made. I personally do not like this procedure, involving as it does the removal of the liberty of the subject, but as an official I should feel bound to make use of it if I should encounter a person who proved unreasonable about the conditions under which they lived. I am glad to say that during 1952 I had no reason to take any such case before the Bench, although in some cases I was driven very close to having to do so, and I feel that sooner or later the necessity for this course of action will arise.

The provision of adequate housing still continues to be of prime importance in promoting and advancing the health and happiness of the community. It is true that the very heavy demand of the years immediately after the war has ceased, especially in the two Rural Districts in this Area, but in the Boroughs and Urban Districts the demand for rehousing continues to be heavy. In this area, the relatively limited size of the building industry has restricted the amount of new building which can be undertaken but within these limitations all the District Councils concerned have done their best to satisfy existing demands.

As far as water supply was concerned the main development was the completion of the trunk main from St. Cleer to Polruan. This willput an end to the severe water shortage which in the past has made life in the summer months so uncomfortable in this popular holiday resort, and in addition will solve the water supply problem at some places along the line of the main notably Dobwalls where a start can now be made in providing some new houses. The next step in this comprehensive scheme would appear to be construction of intake works on the River Fowey, and the provision of a new main from these works to enlarged treatment works and storage reservoirs at St. Cleer. When this is done there should be ample pure water available to serve all the needs of the surrounding area for many years to come, and it will then be possible to consider extending piped water supplies to many villages, hamlets and farms which are badly in need of such supplies.

With the development of water supplies the need will soon arise for more satisfactory systems of sewage disposal. Because of the high cost of providing such systems progress must necessarily be slow, and in consequence the two Rural Districts, in which the principal demand for this service exists, have agreed on a scheme of priorities for the carrying out of this work. Other things being equal, places suffering the greatest nuisance from existing unsatisfactory methods of sewage disposal, are given the highest priority

This means that smaller villages and hamlets, where the extent of the nuisance is less will have to be patient and await their turn, perhaps for some years, since the provision of proper facilities is at present a slow and expensive matter. During the year 1952 the main active work on sewage disposal was at St. Cleer in the Liskeard Rural District, though much time and thought was given to the preparation of schemes in the St. Germans and Liskeard Rural Districts.

I trust that the foregoing paragraphs will give some general idea of those aspects of Public Health work in this Health Area which have interested me and in some respects caused me concern during 1952. My general impression of the year is one in which the health of the community has been about average, and in which there have been no outstanding losses or gains, and I think we can rest reasonably content if not completely satisfied with this result. From a purely personal point of view the year was for me very satisfactory in the cordial relations which existed between members and officers of the District Councils and myself, and I should like to take this opportunity of thanking all those who have helped me and co-operated with me during the year 1952

I have the honour to be,

Mr. Chairman, Ladies & Gentlemen

Your obedient Servant

P.J. Fox.

Medical Officer of Health

LOOE URBAN DISTRICT

Area of Urban District.	1649.5 acres
Population (Registrar Generals Estimate)	3569
Number of Inhabited Houses	1263
Rateable Value	£40,376
Sum Represented by Penny Rate	£162

Vital Statistics for 1952

	Male	Female	Total
Live Births	26	16	42
	Looe U.D.	**Health Area 7**	**England & Wales**
Birth Rate per 1000 of population	12.71	13.86	15.30

	Male	Female	Total
Stillbirths	1	-	1
	Looe U.D.	**Health Area 7**	**England & Wales**
Stillbirth rate per 1000 of population	0.28	0.32	0.35

	Male	Female	Total
Deaths	26	29	55
	Looe U.D.	**Health Area 7**	**England & Wales**
Death rate per 1000 of population	11.40	13.25	11.30

Deaths Attributed to Pregnancy, Childbirth and the Puerperal State

No deaths registered

Deaths of Infants under One Year of Age

	Male	Female	Total
All Causes	2	1	3
	Looe U.D.	**Health Area 7**	**England & Wales**
Infant mortality rate per 1000 live births	71.4	36.4	27.6

Principal Causes of Deaths at All Ages

Heart Disease	26
Cancer (all sites)	11
Respiratory disease	4
Cerebral Vascular lesions (stroke)	2
Circulatory disease	2
Accidents	2

Average Age at death

Males	Females
62.56	74.07

The birth rate is below that of the surrounding area, and that of England and Wales. The death rate is lower than that of the Area as a whole and is only fractionally above the national figure. Heart disease is again the main cause of death with cancer as the next most prevalent cause. For the fifth successive year there has been no maternal deaths in the Urban District. The infant mortality rate is high, although the total number of deaths - 3- is not great.

Infectious Disease. During 1952 the total of 16 cases notified was the lowest in the five year period 1948-52. The most prevalent of the notifiable diseases was pneumonia of which there were 9 cases. The single case of malaria recorded was almost certainly a relapse of an infection originally contracted abroad.
There were no deaths from notifiable infectious disease during the year.
The following are details of actual cases and case rates of infectious disease during 1952:-

		Rates per 1000 of Population		
Disease	Cases	Looe U.D.	Health Area 7	England & Wales
Pneumonia	9	2.52	0.92	0.72
Measles	2	0.56	1.96	8.86
Whooping cough	2	0.56	0.82	2.61
Erysipelas	1	0.28	0.22	0.14
Malaria	1	0.28	0.02	-
Food Poisoning	1	0.28	0.13	0.13

Tuberculosis. Only one new case of tuberculosis of the non-respiratory type was notified in the Urban District during 1952. This is by far the lowest number in the five year period 1948-52, the previous best being in 1950 when 4 cases were notified. Whilst one must be grateful that tuberculosis has suffered this setback in Looe, I do not think it would be wise to be over optimistic about the situation until there is greater certainty that the reduction in incidence will be continued in future years.
There was one death from pulmonary tuberculosis and three cases of pulmonary tuberculosis were romoved from the tuberculosis register fro various other reasons. As a result of this there were at the end of the year 20 known cases of pulmonary tuberculosis, and 4 known cases of non-pulmonary tuberculosis on the register for the Urban District.

In following up contacts of tuberculosis 11 susceptible contacts (negative reactors) were discovered, and were given B.C.G. vaccination. One other susceptible contact was offered B.C.G. vaccination but refused to accept it. Of the 11 susceptible contacts requiring B.C.G. vaccination 10 were below the age of 15 years, 7 of these being 5 years or under.

The following are details of new cases and case rates for the year 1952:-

Age Group	New Cases M.	New Cases F.	Deaths M.	Deaths F.
0 - 1	-	-	-	-
1 - 5	-	-	-	-
5 - 15	-	-	-	-
15 - 45	1	-	-	1
45 - 65	-	-	-	-
65 and over	-	-	-	-

Rates per 1000 of population

	Looe U.D.	Health Area No. 7
New Cases	0.28	1.01
All Cases	6.72	5.62
Deaths	0.28	0.11

National Assistance Act. 1948. No action under Section 47 of this Act was called for during 1952.

Water Supply The South-East Cornwall Water Board provided an adequate supply of pure, treated water throughout the year.

Sewerage and Sewage Disposal. There are no developments or changes to report.

Food. Where time and pressure of other work allowed Mr. Hicks in his capacity as Sanitary Inspector carried out some inspections of premises in which food is handled, and prepared for sale or consumption. Because of the diversity of work which he has to do he was not able to carry out such inspections with sufficient regularity or sufficiently often to make them of real value. During the holiday season when the population of Looe increases three or fourfold, and the climatic conditions for the occurrence of food poisoning are most favourable, the handling and preparation of food in shops, and catering establishments needs regular supervision. In a popular resort such as Looe, catering is a major industry, and as such it is vital to the reputation of the Urban District that it is well conducted.

Food Poisoning Only one isolated case was notified during 1952.

Clean Food Campaign. For the reasons given in an earlier paragraph it was not possible to organise a campaign in 1952.

Housing. On the Council's Sunrising Estate 15 houses were completed during 1952, bringing the total number of houses occupied on this estate to 95. Demand for rehousing continues to be heavy in Looe, and it will be some time before outstanding lists of applicants can be cleared. During the year 10 houses built under private enterprise were occupied.

Factories Act, 1937 The number of factories coming within the scope of this Act is small - 10 in all - and no difficulties were experienced during 1952.

Report of the Sanitary Inspector - This report by Mr.J.C. Hicks, C.R.S.I. follows. In spite of being very busy by reason of the variety of duties he has to cope with I have always found Mr. Hicks cheerful, willing, and most co-operative and I have to thank him for the assistance he has given me during the year.

Report of Sanitary Inspector.

Factories, Workshops and Bakehouses.

These were periodically inspected.

1. Inspections for purposes of provision as to health (including inspections made by Sanitary Inspectors) Factories Act, 1937

		No. on Register	Inspections
(i)	Factories in which sections 1,2,3,4 and 6 are to be enforced by Local Authorities	10	43
(ii)	Factories not included in (i) in which section 7 applies	-	-
(iii)	Others	3	5
		13	48

2. Cases in which defects were found

Particulars	Defects Found	Defects Remedied	Referred to H.M. Inspector
Want of Cleanliness (S.1)	1	1	-
Ineffective drainage of floors	-	-	-
Sanitary Conveniences	1	1	-
Other	-	-	-
	2	2	-

Ice Cream and Other Samples

There are four Ice Cream Factories in the District. During 1952 seventy two samples of Ice Cream were taken for evidence of bacterial contamination and for grading, and eighteen of these were analysed for fat content.

The results were as follows:-

51 Grade 1
10 Grade 2
11 Grade 3
0 Grade 4

The fat content in the samples analysed was satisfactory.

Milk Sample

After complaints had been received regarding the cleanliness of milk received at the Looe Secondary Modern School a sample was taken on the 29th October, 1952, and was found to conform with the standard for T.T. (Past.) Milk.

Food Canning

During the year the undermentioned was dealt with at the Canning Factory:-

14 oz Oval Pilchards	1125333	
Other Fish	18846	1144179
7 oz Oval Pilchards	771863	
Other Fish	25921	797784
No. 1 Tall Pilchards	152993	
Other Fish	26145	179138
½ Dingley Other Fish		12076
Total Cans of Fish		2133177
No 1 Tall Processed Peas		437950

Water

During the year the water supplied continued to be satisfactory as regards quality and quantity.

The Wayland Supply which is feeding the Canning Factory continues to give good service, and it was not found necessary to put the Factory onto the Main Town Supply at any time during the year

In October 1952 a periodical check was made and a sample taken, the report being satisfactory.
A sample was also taken of the Town Supply and the result was satisfactory.

Meat and Other Foods

During the Year the following were condemned as unfit for human consumption.

96 Tins Various Foods
2½ stones Fish
9 Tins Cooked Ham. Weight ¾cwt 15 lbs 14ozs

Refuse Collection

The system operating during 1951 was continued, and the Refuse is disposed by Incinerator.
Refuse is collected from 1504 premises.

Inspection of Dwelling Houses etc.

Total number of dwelling houses inspected for defects	91
Other complaints i.e. drainage	26
Hotels Cafes etc	16
	133

J.C. HICKS

Surveyor and Sanitary Inspector

Looe U.D.C.

APPENDIX 1.

PRINCIPAL CAUSES OF DEATH - ALL AGES -1952

DISEASE	St. GERMANS R.D.	LISKEARD R.D.	SALTASH M.B.	TOR POINT U.D.	LISKEARD M.B.	LOOE U.D.	HEALTH AREA NO. 7
HEART DISEASE	79	95	38	15	26	26	279
CANCER (ALL SITES)	33	15	15	12	16	11	102
CEREBRAL VASCULAR LESIONS (STROKE)	29	16	20	11	8	2	86
RESPIRATORY DISEASE	20	13	3	3	5	4	48
CIRCULATORY DISEASE	16	8	7	3	1	2	37
GENITO-URINARY DISEASE	7	4	8	3	1	-	23
ACCIDENTS	7	4	3	2	-	2	18
DIGESTIVE DISEASE	3	3	2	1	-	1	10
SUICIDE	4	1	-	-	-	1	6
TUBERCULOSIS	1	2	1	-	1	1	6

APPENDIX 2

DETAILS OF TYPES OF HEART DISEASE AND CANCER CAUSING DEATHS. 1952

TYPE OF DISEASE	St. GERMANS R.D.	LISKEARD R.D.	SALTASH M.B.	TOR-POINT U.D.	LIS-KEARD M.B.	LOOE U.D.	HEALTH AREA No. 7.
CORONARY DISEASE ANGINA	26	25	13	7	5	6	82
HIGH BLOOD PRESSURE WITH HEART DISEASE	5	8	2	-	2	1	18
OTHER HEART DISEASE	48	62	23	8	19	19	179
CANCER OF STOMACH	5	3	2	2	2	6	20
CANCER OF LUNG & WINDPIPE	1	-	1	1	1	1	5
CANCER OF BREAST	4	1	1	-	3	1	10
CANCER OF WOMB	3	2	4	3	1	-	13
VARIOUS OTHER CANCERS	20	9	7	6	9	3	54

APPENDIX 3

DEATHS BY AGE GROUPS - 1952

DISTRICT	0 - 5 YEARS	5 -15 YEARS	15 -45 YEARS	45-65 YEARS	65-75 YEARS	75yrs UPWARDS	ALL AGES
ST. GERMANS R.D.	10	2	7	43	61	112	235
LISKEARD R.D.	7	-	5	36	42	92	182
SALTASH M.B.	5	-	10	24	31	47	117
TORPOINT U.D.	2	-	4	16	14	23	59
LISKEARD M.B.	3	-	5	12	17	24	61
LOOE U.D.	2	-	4	9	16	24	55
HEALTH AREA NO. 7.	29	2	35	140	181	322	709

APPENDIX 4

AVERAGE AGE AT DEATH-1952

DISTRICT	MALES	FEMALES
ST. GERMANS R.D.	70.01	66.77
LISKEARD R.D.	69.02	71.60
SALTASH M.B.	64.38	67.69
TORPOINT U.D.	61.59	67.07
LISKEARD M.B.	64.45	65.15
LOOE U.D.	62.56	74.07
HEALTH AREA NO. 7	67.27	68.47

APPENDIX 5

INCIDENCE OF, AND MORTALITY FROM TUBERCULOSIS IN HEALTH AREA NO. 7 - 1952

AGE GROUP	NEW CASES		DEATHS	
	M.	F	M.	F.
0 - 1	-	-	-	-
1 - 5	-	-	-	-
5 - 15	4	5	-	1
15 - 45	19	12	1	1
45 - 65	7	4	1	1
65 and over	3	-	1	--
TOTALS	33	21	3	3

	MALES	FEMALES
CASE RATE PER 1000 OF POPULATION	0.64	0.39
MORTALITY RATE PER 1000 OF POPULATION	0.06	0.06

CASE RATES AND MORTALITY RATES PER 1000 OF POPULATION BY SANITARY DISTRICTS IN HEALTH AREA NO. 7 - 1952

DISTRICT	NEW CASES	TOTAL CASES AS AT 31.12.52	DEATHS
ST. GERMANS R.D.	0.72	5.63	0.06
LISKEARD R.D.	1.46	4.53	0.14
SALTASH M.B.	1.00	5.63	0.13
TORPOINT U.D.	1.17	5.57	NIL
LISKEARD M.B.	1.40	8.37	0.23
LOOE U.D.	0.28	6.72	0.28
HEALTH AREA NO. 7	1.01	5.62	0.11

APPENDIX 6

B.C.G. VACCINATIONS AGAINST TUBERCULOSIS - 1952

DISTRICT	AGE GROUP UNDER 1 Year	1 - 5 Years	5 -10 Years	10 - 15 Years	15 Years and Over
ST GERMANS R.D.	3	12	12	8	4
LISKEARD R.D.	2	5	7	6	3
SALTASH M.B.	3	9	3	5	2
TORPOINT U.D.	1	4	1	1	-
LISKEARD M.B.	3	6	6	1	2
LOOE U.D.	1	2	6	1	1
HEALTH AREA NO. 7	13	38	35	22	12